Georgia Department of Community Health

Division of Health Planning
2 Peachtree Street, NW
5th Floor
Atlanta, GA 30303

2006 HOME HEALTH SERVICES SURVEY (HHSS)
INSTRUCTIONS
January 1, 2006 through December 31, 2006

- IMPORTANT NOTICE ABOUT SURVEY ACCURACY AND COMPLIANCE -

The information and data collected through this survey are used for state regulatory and planning purposes and are made available to public officials, advocacy groups, health care purchasers, and consumers. This survey is required under Department of Community Health Rule 111-2-2-.04 and other regulations. The failure to properly submit and/or fully complete all required surveys may result in adverse regulatory action pursuant to DCH Rules 111-2-2-.05, .09 and other regulations or statutes.

The chief executive officer or principal administrator of the facility (who shall attest to the accuracy and completeness of the information provided) and your organization are responsible for ensuring the accuracy of the information and data reported in this survey. The sole responsibility for accuracy resides with the organization and the officials filing the survey. Accuracy at time of submission is particularly important. See Rule 111-2-2-.04(e) prohibiting survey revisions unless approved by the Department at its sole discretion.

Providing false or inaccurate information may result in adverse regulatory action pursuant to DCH Rules 111-2-2-.04(1)(b), 111-2-2-.05(1)(a)1, and 111-2-2-.05(1)(a)7, other regulations and statutes, and may constitute a crime under O.C.G.A. §§ 16-10-20 and 16-14-1.

2006 HOME HEALTH AGENCY SURVEY ACCESS FORM

The 2006 Home Health Services Survey (HHSS) is a Microsoft Access database. You must have Microsoft Access 2000 or a later version of Access in order to open the database and complete your survey. **Microsoft Access 97 is no longer supported.**

IF YOU NEED ASSISTANCE

When you are working in the database, you may view these instructions by clicking the Help button found on each form. You can get specific instructions for any **underlined item in blue** on the form by clicking the item.

If you can't find the answer to your problem on the Help screens, check the "Frequently Asked Questions" link on the web page where you downloaded the database. This document will be updated periodically as new questions arise.

If you still have any questions after reviewing the documentation above, please contact Carlos Williams at (404) 656-0464 or by email at cawilliams@dch.georgia.gov.

INSTRUCTIONS FOR SUBMITTING THE DATABASE

The deadline for filing the completed survey database for your agency is April 13, 2007.

Once you have completed your survey and resolved any data validation issues, you should electronically submit the survey to the Department of Community Health (DCH). ***Please do not fax or mail a hard copy***. Follow the steps below to submit your survey:

You must sign the Signature Form before submitting the database. The survey will not be deemed complete without an authorized signature.

Be sure to print a copy of your completed forms before submission and retain a copy of the Access file for your records.

To submit your database, click the green Upload button on the survey opening screen and follow the on-screen instructions. Email submissions of survey databases will ***no longer be accepted***. However, you may send any supplemental documents via email to the address listed in the previous section.

Survey Completion Status – Typically, a survey will be considered complete when a signed, completed version is received by the Division of Health Planning. All requested data elements must be provided; edit check, error messages, and validation rules must be addressed or in balance; and the survey must be signed in the appropriate location and manner. Once received and determined to be complete by the Division, the survey is considered a public record. DCH staff may not be able to process your survey immediately due to high volumes of survey submissions. You may follow-up a few days after submitting your survey to make sure your survey has been processed and is considered complete by the Division of Health Planning. The completed survey will be deemed complete on the day it is received by DCH even if it is processed later. The completion status of all surveys for each facility will be published on the DCH website on or after the survey due date**. It is extremely important that you retain a copy of your completed survey (both the Access database and a printed copy).**

Revising or Amending the Survey – Pursuant to Rule 111-2-2-.04(1)(e) surveys that are received and determined to be complete by the Division of Health Planning may not be revised after the survey due date without approval by DCH. Requests to revise must be submitted in writing to the Division of Health Planning with a detailed explanation of the revisions and any necessary documentation. The Division of Health Planning will consider revisions on a case-by-case basis and reserves the right to deny a request to revise. The Division may also determine that additional data, information, or documentation is needed to support the proposed revisions.

INSTRUCTIONS FOR COMPLETING THE SURVEY FORM

The Access database file may either be saved to a single computer or to an internal computer network. The database can be placed on a network so that multiple users can access and complete (or review) the survey at different times. Please be sure not to make copies of the database. Only one version of the database should be sent to DHP. The Access file should open automatically to an opening screen where you can select a form to complete or view. You should be able to print a blank copy of the survey from the "print" button included on each form or from the opening screen. Select your agency from the drop-down menu on the survey form. Enter your facility's data using the survey form. Please be sure to provide an answer in every question. If the question does not apply to your agency please indicate "not applicable". Access does not have a "save" feature like other applications. Each change you make to the form will be saved automatically.

INSTRUCTIONS FOR COMPLETING THE SIGNATURE FORM

The database contains two types of forms. The first type is the survey form described above. This form is used to collect utilization data and information. The Signature Form is where the facility's chief executive or administrator electronically authorizes the survey for release to the Department of Community Health. The facility's chief executive officer or administrator must sign to certify that the responses are complete and accurate for the report period specified. A typed version of the signature is being accepted as an original signature pursuant to the Georgia Electronic Records and Signature Act.

The Signature Form also will identify any out of balance edit checks and any validation rule criteria that are not correct. The edit checks must be resolved before the authorized signature will be accepted by the database. For example, if your total patient counts are not in balance when requested, then the Signature Form will indicate that they are out of balance and may not accept the authorized signature until the patient counts are corrected. In other cases the database will provide a warning message to inform you that certain totals do not balance that should be in balance. Please make every effort to resolve these data issues. The form may also indicate that certain responses are not valid either for your facility type or authorization. Unresolved issues must be addressed by an explanation in the provided comments box if the data is not changed or amended.

Data Validation Requirements – All edit and balance requirements and all required fields must be completed before the facility's administrator or chief executive can authorize the survey. You can determine if the required survey totals are in balance and that all required items are complete by clicking the "View Error Messages" button in the Data Validation Requirements section at the top of the Signature Form. This button produces the Data Validation Report containing a description of any out of balance totals and any required data items that are missing. The Data Validation Report can be printed and should be rerun until all items have been corrected. **Each item on the Data Validation Report must be corrected before the form will accept the authorized signature.**

PART A: GENERAL AGENCY INFORMATION

Agency Name and Address - Please provide your agency's current name and address as requested.

Medicaid and Medicare Provider Numbers - Respond as requested. Please be sure to provide both the home health agency's Medicaid and Medicare provider numbers. Enter numbers and no dashes or alpha characters.

Report Period - January 1, 2006 through December 31, 2006 is the **required** report period. If the agency was in operation for a full year **you must** report data for a full year. If the ownership, operation or management of the facility changed during the report period, it is the responsibility of the **current owner or operating entity** to obtain the necessary data from the prior owner or operator.

PART B: SURVEY CONTACT INFORMATION

Please provide contact information for the individual authorized to respond to questions regarding your agency's survey submission.

PART C: AGENCY OWNERSHIP, OPERATION AND MANAGEMENT INFORMATION

Please provide the following information as applicable to your facility. If certain fields do not apply the form will allow you to enter only "Not Applicable" in the Full Legal Name column.

Agency Owner - The person or entity that owns the building and grounds. Include the appropriate organizational code and the effective date by month, day and year.

Agency Operator - The owner of the business entity who is accountable for the profits and losses of the agency. Include the appropriate organizational code and the effective date by month, day and year.

Management Contractor - A specific entity with whom the Owner or Operator has contracted to manage the routine business of the agecy. Include the appropriate organizational code and the effective date by month, day and year.

Branch Office – For the purposes of this survey, branch office is defined as any other office locations within the approved service area in addition to the headquarters office where home health care services are also provided.

PART D: AGENCY UTILIZATION AND PATIENT CASELOAD INFORMATION

Home Health Visit – A home health visit occurs when a patient receives a health-related service from your agency by agency staff at the patient's home, in an outpatient setting, or other residential setting and for which a chargeable or reimbursable cost is incurred. Please be aware that all visit totals must balance throughout the survey.

Total Visits and Per Visit Charge by Service Discipline – Provide the total number of visits made for home health services by each of the service disciplines listed as appropriate. Also, please provide the per visit rate your agency charges for providing each of the services indicated.

Total Agency Caseload – Caseload is defined as the number of patients. This is determined by taking the number of patients at the beginning of the report period on January 1, 2006, adding the number of new patients (admissions) and subtracting the number of discharges during the year ending December 31, 2006.

Medicare Episodes of Care – Provide the total number of Medicare episodes of care that were completed during the report period. A Medicare episode is no more than 60 days in length and is the unit of payment for home health Prospective Payment System. The episode payment is specific to an individual patient and the 60-day episode begins with the first Medicare billable visit as day one and ends on and includes the 60th day from the start-of-care date. Include completed episodes that were less than 60-days such as Medicare Low Utilization Payments Adjustments (LUPA).

Patient Race/Ethnicity (as defined by the U.S. Census Bureau) – Please report the number of unduplicated health-related patients using the following categories. Please note that total patient counts should balance throughout the HHSS.

American Indian or Alaska Native - A person having racial origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
Asian - A person having racial origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, but not limited to, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
Black or African American – A person having racial origins in any of the Black racial groups of Africa.
Hispanic or Latino – A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term "Spanish Origin" can be used in addition to "Hispanic" or "Latino."
Native Hawaiian or Other Pacific Islander – A person having racial origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
White – A person having racial origins in any of the original peoples of Europe, the Middle East, or North Africa. Include people who indicate their race as "White" or report entries such as Irish, German, Lebanese, Near Easterner, Arab, or Polish.
Multi-Racial – A person having racial origins from two or more of the above definitions.

Patient Gender – Please report the total patients by gender. Note that the total patients by gender should balance to total patients reported by race/ethnicity and must balance to total patient counts by patient origin.

Payer Source – Please report the total unduplicated patients, total visits, and revenue by the patient's primary payer source. Other Third-Party Insurance should be for patients covered by a private carrier, but not covered under a managed care plan (a fee-for-service or indemnity plan). Managed Care should be for patients covered by a private, third-party carrier, but covered under a managed care plan such as an HMO or PPO where a rate has been negotiated. Other Non-Government should be used for patients covered by any other type of insurance, but not a government program.

PART E: AGENCY FINANCIAL SUMMARY, INDIGENT AND CHARITY CARE PROVIDED, AND PATIENT POINT OF ORIGIN

Indigent Care – Report as indigent any unpaid charges for services to patients whose family income is less than or equal to 125% of the Federal Poverty Guidelines. Do not include unpaid charges for patients who were eligible for Medicare, Medicaid, Third Party, or patients provided free care.

Charity Care – Report as charity care any unpaid charges for services to patients whose family income is greater than 125% of the Federal Poverty Guidelines, and which were provided in accordance with the agency's formal written charity care policy, and which were written off to a formal charity account in the agency's accounting records. Charity care represents that portion of health care services that are provided but where payment is not expected. Charity care is provided to a patient with demonstrated inability to pay for some or all of the service. Only the portion of a patient's account that meets the organization's charity care criteria is recognized as charity.

***Indigent and Charity Care Write-Offs:* Unpaid charges for indigent and charity care cases should be related only to the provision of licensed home health services as defined above for a home health visit. Unpaid charges from other lines of business should not be included.**

Gross Patient Revenue – Gross patient review includes charges generated by all patients at full-established rates before provisions for contractual and other adjustments are applied. Please include any revenue forgone for provision of care for indigent/charity patients at full-established rates. Gross Patient Revenue must balance throughout the survey.

Contractual Adjustments – Contractual adjustments represent any charges that are not paid by third-party payers and cannot be billed to the patient pursuant to contractual agreements. Contractual adjustments for Medicare, Medicaid and other payers are reported separately in the Annual Home Health Survey.

<u>Net Medicare Revenue vs. Gross Medicare Revenue:</u> When Medicare reimbursement exceeds the agency's gross charge the difference should be reported as patient revenue and not as a contractual adjustment.

Bad Debt – Bad Debt is an amount that a party has an obligation to pay but that is considered uncollectible. Bad debt represent the portion of a patient's account not expected to be collected from the patient or other responsible party (the patient's portion). The patient's portion of a bill should not be categorized as a bad debt for patients whose income is less than or equal to 125% of the federal poverty guidelines. Bad debt must be differentiated from charity services. Patient charges otherwise eligible for classification as charity care should only be treated as bad debt if all conditions of your agency's charity care definition are not met.

Gross Indigent and Charity Care Patient Charges – Gross indigent and charity charges are the total uncompensated charges for patients who qualify as indigent or charity under the definitions above.

Total Indigent and Charity Compensation – Funds provided by all public and private sources that are earmarked as compensation to offset uncompensated charges from indigent or charity care cases.

Other Free Care – Other uncompensated care provided as a result of employee discounts, administrative adjustments, courtesy discounts, small bill write-offs, or other similar write-offs not based on a patient's inability to pay. Should not include amounts properly classified as "contractual adjustments" as defined above.

Other Revenue - Other revenues or gains are derived from services other than providing services to patients. This may include revenues shared with the agency from another organizational entity (hospital, long term care facility, etc.)

Total Expenses - The sum of resources consumed in fulfillment of an agency's ongoing major or central operations. Expenses may result from current expenditures, incurring obligations to make future expenditures, or consuming resources obtained from previous expenditures. Expenses associated with non-home health agency services should be excluded from the Survey. Expenses related to activities shared with entities other than the agency (such as a hospital) should be allocated between the entities. The expense component not allocated to the agency should be eliminated from the Survey. Appropriate matching of the revenues and expenses excluded from the Survey should be made. Do not include bad debt as a total expense, but as a deduction from revenue.

Adjusted Gross Revenue -- Adjusted Gross Revenue (AGR) is calculated by subtracting Medicaid and Medicare contractual adjustments *only* and bad debt from the agency's total gross revenues. AGR is used as the basis for determining an agency's level of uncompensated indigent and charity care services. Generally, these figures are presented as a percentage of the facility's AGR.

Calculated Financial Totals – The following financial items will be automatically calculated automatically by the survey database from the financial information provided on the survey form.

Total Contractual Adjustments
Uncompensated (Net) Indigent Care Total
Uncompensated (Net) Charity Care Total
Total Uncompensated Indigent and Charity Care
Total Net Patient Revenue
Total Net Revenue
Adjusted Gross Revenue (as defined by DCH)
Percentage of AGR that is Uncompensated I/C Charges

Indigent and Charity Care Commitments – Some home health agencies have commitments to provide a specified level of indigent and charity care as part of their Certificate of Need authorization. For those agencies that have a CON commitment to provide indigent and charity care, the commitment (expressed as a percentage) is multiplied by the agency's AGR to calculate the amount of uncompensated indigent and charity care provided.

Indigent and Charity Care Patients – Report the number of home health care patients who were classified as indigent or charity care cases consistent with the definition provided above. Report only indigent and charity care patients who received home health care services and who had charges included in the indigent or charity care reported in Part E, Question 4.

Healthcare Point of Origin – Report the number of patients referred from each of the categories listed as applicable. The point of origin should represent the setting from which the referred patient was referred home. For example, if a patient is referred for home health care by a hospital discharge planner or another individual working under the auspices of the hospital then the point of origin should be hospital. If a patient is referred for home care directly from a physician or physician's office visit then the point of origin is physician. The point of origin should represent the healthcare setting in which the patient was treated last before home.

Referring Hospitals – Please list the name of hospitals from which patients were referred to your agency during the report period and provide the number of patients from each hospital that were referred during the report period.

PART F: AGENCY WORKFORCE INFORMATION:

The Division of Health Planning collects workforce information to support the State's workforce planning activities. The Division is currently focusing on planning efforts for Registered Nurses, Licensed Practical Nurses, Nurse Aides/Assistants, and other direct care staff. Please report the budgeted number of full-time staff (FTE) and the number of vacancies as of **December 31, 2006**. Please note that this reporting period is different than the Calendar Year used throughout the rest of the survey.

Also, please report the average time your facility has spent during the past six months filling vacant positions. Use one of the four time periods provided for each professional category.

PART G: MONTHLY ADMISSIONS AND READMISSIONS AND UTILIZATION BY PATIENT COUNTY

Monthly Number of New Admissions -- Provide the number of new admissions for each of the 12 months of the report year. A new admission is a patient admitted for the first time during this report year and who was not captured in the caseload total reported for 1/1/2006. A person should be counted as a new admission only once during the report year.

Monthly Number of Re-Admissions – Provide the number of readmissions for each of the 12 months of the report year. A readmission is a patient who was admitted previously during the 2006 report year.

Patients and Visits by Patient County by Age -- Please report the number of patients served and number of visits made by the patient's resident county for your agency during the report period. The caseload as of January 1, 2006 should represent the total number of patients your agency served on that day. Please be aware that patient and visit totals must balance throughout the survey. Please note that the Total Patients column will be calculated by the survey form from the patients provided in each age group. However, the Ages 60 to 79 column is not included in the calculation of total patients. We are seeking patients ages 60 to 79 for informational purposes only and this category stands alone.

The HHSS is due at the Department of Community Health by April 13, 2007. Submit the survey electronically using the instructions provided above. For questions regarding the HHSS or if you are unable to submit the survey electronically, please contact Carlos Williams with the Division of Health Planning at (404) 656-0464, or cawilliams@dch.georgia.gov.